Sheffield Teaching Hospitals NHS Foundation Trust

RHQ

Community health services for adults

Quality Report

Northern General Hospital, Herries Road , Sheffield,
South Yorkshire, S5 7AT
Tel: 0114 2434343
Website: http://www.sth.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RHQNG	Northern General Hospital	NA	NA

This report describes our judgement of the quality of care provided within this core service by Sheffield Teaching Hospitals NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Sheffield Teaching Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of Sheffield Teaching Hospitals NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Overall rating for this core service Outstanding

Overall we found services for community adults to be outstanding.

There were robust methods of reporting, investigating and learning from incidents and near misses that staff understood and embedded in their daily work. There was a risk register in place that ensured potential risks were known, assessed and appropriate controls were implemented. Pharmacists worked with community teams and had written and reviewed standard operating procedures to improve safety around medicines.Compliance with mandatory training was generally high and we observed good infection control practices. We found that staffing levels met the needs of patients.

We found care and treatment was evidenced based with pathways of care based on National Institute of Clinical Excellence (NICE) guidelines. There were excellent examples of multi-professional teams working closely together for the benefit of patients. Referrals to community services were managed by the Single Point of Access (SPA) service, which established the most appropriate service for the patient. Staff had good access to records using laptops with 4G and used an electronic patient record system allowing information to be shared between professionals. Staff we spoke to had a good level of knowledge about the Mental Capacity Act and Deprivation of Liberty Safeguards.

Caring was good. We found staff were genuinely caring and passionate about the care they provided to patients. Patients we spoke to all said they were extremely happy with the care they received and felt they were always treated with compassion. Patient's relatives said they thought the care provided had been excellent and staff had been caring and responsive. We observed staff treating patients with dignity and respect. Patients and their relatives were involved in their care. We observed treatment and support options being discussed with patients and their families before gaining consent and agreement. Emotional support was made available for example; mental health services aligned to the active recovery team provided talking therapies for patients and could signpost patients to other agencies. We saw staff putting on overshoes when entering patients home in wet weather. We thought this was extremely considerate.

Community services were exceptionally responsive. There was close working with commissioners to provide services along coordinated pathways of care. We saw good examples of community services working closely and planning services with the acute hospitals to provide integrated care to patients. The active recovery team had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess. The first ward to implement discharge to assess had a sustained reduction in length of stay of 7 days. Access to services via the single point of access was excellent, ensuring patients were seen by the right professional at the right time at a venue of their choice. Staff were aware of cultural differences. Patient information leaflets were available in different languages and there was good access to interpreting services. Community nursing teams had a dedicated member of staff who was the dementia link. Staff we spoke to had completed dementia training and could describe how they would provide extra support for patients living with dementia. There was shared learning from complaints and we saw evidence that changes were made in response to complaints.

Community services were extremely well led. Senior managers could articulate their vison and strategy and shared this with staff. There was strong leadership at both senior and local level. Staff spoke highly of their managers and felt well supported and listened too. Senior managers were often seen and staff said they were approachable. Staff engagement was outstanding. The trust used different methods of engaging the staff such as the 'listening into action' events and 'you said we did' initiatives. Staff were consulted with and encouraged to lead on service development and change and they felt empowered and valued. There was a positive culture of service improvement and we found innovative services along pathways of care, which reached across both hospitals, and community services.

Summary of findings

Background to the service

Information about the service

Community services joined the Sheffield Teaching Hospitals NHS Foundation Trust in 2011 as part of the transforming community services programme designed to move care out of hospitals and closer to people's homes. Community services had approximately 1,400 staff.

Trust services were managed within nine Care Groups. Each Care Group had a number of Clinical Directorates within it. The majority of community services for adults were within the Combined Community and Acute Care Group. Some services such as PhysioWorks were within the Musculo-skeletal Care Group.

Community services we inspected:

Integrated Community Nursing Team - There were 23 integrated community nursing teams including evening and night teams. Teams were managed within four localities across then city, which mirrored GP localities in the local Clinical Commissioning Group (CCG). These were HASC, Central, West and North. Within each locality, Band 7 team leaders managed teams of nurses and support workers. Community matrons were attached to localities and provided support to patients with complex long term conditions.

Active Recovery Team – a jointly provided service between health and social care that puts in place interventions and treatments to support patients in their own homes. The service aims to reduce un-necessary hospital admissions and facilitates the timely discharge of more complex patients from hospital.

Specialist Heart Failure Nursing Team work with consultants and GP's to try to prevent people being admitted to hospital and to offer support to patients so they can return home following a period in hospital.

We also inspected the Evening and Night Nursing Service, the Integrated Community Therapy Team, Podiatry, PhysioWorks, Telehealth, the Single Point of Access, the Community Stoke Team, the Community Falls Prevention Service and services provided by the Tissue Viability Nurses.

During our inspection, we spoke to 81 members of staff including, pharmacists, nurses, rehabilitation assistants, team leaders, physiotherapists, podiatrists, occupational therapists, administration staff and senior managers. We observed care being provided both in clinics and in patient's homes. We spoke with 22 patients and looked at 22 patient records.

Our inspection team

Our inspection team was led by:

Chair: Professor Stephen Powis, Medical Director

Team Leader: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists including a community matron, a district nurse team leader, a specialist nurse and a physiotherapist.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection programme.

Summary of findings

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 07-11 December 2015.

What people who use the provider say

Friends and Family Test data for community services for September, October and November 2015 showed that were consistently between 80-90% for patients who would recommend the service to their friends and family.

Good practice

The active recovery service was a responsive service, which put in place interventions and treatments to support patients in their own homes. The service aimed to reduce un-necessary hospital admissions and facilitate the timely discharge of more complex patients from hospital. The team was multidisciplinary and multiagency with health and social care working closely together. The service had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess. We thought this was an outstanding service with excellent outcomes resulting in reduced length of stay for patients and improved patient flow within the hospital. The team had won an award for cost efficiency.

The Single Point of Access (SPA) service managed referrals from patients and health professionals into all community health services. It received approximately 2100 call per month and was available 365 days a year, from 8 am to 10pm. Outside of these hours the calls were answered by the GP Collaborative. The service used a call routing system to direct patients to the right professional from the start. The team had extensive local knowledge and specialist expertise and were able to access to up to date information on service capacity. This meant that they could give advice on which service would be most appropriate for the patient. Once referred to a service, confirmation was sent to referrers to ensure they were kept informed of who was caring for their patients. The aims of the service were to ensure patients were seen by the right professional at the right time at a venue of their choice. We thought this service was outstanding.

We thought the person centred care planning outstanding. The aim of this was to provide support for patients considered to be at high risk of hospital admission at an early stage. Community nurses and GPs worked together to develop patient and carers confidence in managing their own health. The community matron supported this. There were locality champions for person centred care planning in each of the four localities.

Staff engagement was outstanding. The trust used different methods of engaging the staff such as the 'listening into action' events and 'you said we did' initiatives. Staff were consulted with and encouraged to lead on service development and change. They felt listened to, empowered and valued.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that all policies are reviewed and up to date.
- Ensure that patient risk assessments are fully completed in all community nursing patient records.
- Review the facilities in which some clinics are held to ensure they comply with infection control standards.

Sheffield Teaching Hospitals NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safety of community adults services as good because;

- There were robust methods of reporting, investigating and learning from incidents and near misses that staff understood and embedded in their daily work.
- There was a risk register in place that ensured potential risks were known, assessed and appropriate controls were implemented. There were plans to deal with major incidents or events that would disrupt the delivery of care.
- Compliance with mandatory training was generally high.We saw variation between some teams and staff groups with therapy teams achieving higher levels of compliance compared to some community nursing teams.
- Infection control practices were generally good; we observed good use of personal protective equipment and hand hygiene.

However;

- We found that some of the buildings were old and required some updating. We saw peeling paint on the walls of some clinical rooms.
- There were inconsistencies in the completion of risk assessments in patients' records in one of the community nursing teams.

Detailed findings

Safety performance

- There were no serious incidents or never events reported in the last year. Forty six incidents had been reported between July 2014 and August 2015.The majority (96%) of the incidents were classified as either insignificant or minor in severity.
- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysing patient harm. The improvement tool focuses on four avoidable harms; pressure ulcers, urinary tract infections in patients with a catheter (CUTI) and venous thromboembolism (VTE). Community services did not report on VTE as part of the safety thermometer.

Good

Are services safe?

- We looked at the safety thermometer data for community services for the period August 2014 to September 2015 and found that there had been 12 falls with harm and 13 new pressure ulcers reported within this period. There were no urine infections in patients with catheters (CUTIs) reported. We saw that there were three months of harm free care, February, March and August 2015.
- Staff told us they used the same safety thermometer standards as the Hospital and they collected and submitted the data on their own patients.

Incident reporting, learning and improvement

- Staff understood how to report incidents using the electronic reporting system. They confirmed that feedback was received and said that learning from incidents was shared across all teams. Staff and managers said that there was a good culture of incident reporting in community services.
- A member of staff gave an example of how the Medical Administration Record (MAR) chart had been updated in response to an incident relating to a drug error.
- Managers told us they looked at all incidents to identify trends and themes. If an issue related to the competence of an individual member of staff, they would be retrained and their competence reassessed.
- Staff we spoke to had a very good understanding of the Duty of Candour.

Safeguarding

- The chief nurse was the executive lead for safeguarding for both adults and children and the deputy chief nurse had operational responsibility for safeguarding.There was a lead nurse for safeguarding adults and the trust was in the process of recruiting a named doctor post for safeguarding.
- Community staff had a good understanding of safeguarding and could give examples of the types of abuse they needed to look for. For vulnerable patients, staff said they would complete a Vulnerable Adults Risk Management Model (VARMM) assessment form.
- Staff we spoke to were aware of the reporting mechanism for safeguarding issues. Staff in the active recovery team gave an example of attending a multi-agency meeting for a vulnerable patient.
- Staff knew that they could contact the trust safeguarding team if they needed advice.
- The trust target for staff training in safeguarding was 90%. Compliance varied across teams with some achieving above the target at 100%. The lowest was community nursing achieving 44% for safeguarding adults level 2 training.

Medicines

- Community services had a Head of medicines management. Pharmacists worked with community teams and had written and reviewed standard operating procedures to improve safety around medicines.
- The community pharmacy team had introduced the use of 'tiny tags' which tracked the medicines fridge temperature. Tiny tags were also used to check that cool packs were kept at the correct temperature when staff were transporting vaccines.
- We observed syringe drivers in patients homes were in a lockable case to prevent unauthorised access and tampering with.
- Rehabilitation assistants in the active recovery service were able to administer medicines to patients following the medicines administration chart. Sometimes they would prompt patients to take their own medicines. We saw this documented in patient care plans. The assistants had received medication training from the pharmacy team and had their competencies checked and signed off. We observed a copy of the training and competency framework. Assistants had access to advice from a pharmacist seven days a week if they were unsure about anything.

Environment and equipment

- We found that some of the community buildings in which services were provided to patients were old and required some updating. One clinic had peeling paint on the walls of the treatment room and there was dust on some surfaces and underneath the patient couch.
- Some clinical equipment, for example specimen pots and syringe infusion sets were stored in cardboard boxes on the floor, which is not good infection control practice.

Good

Are services safe?

- Equipment had been PAT tested and next service dates were recorded to ensure that they were maintained in line with manufacturers' recommendations. We noted that the dates for servicing were in date.
- We saw that sharps were safely managed and disposed of in line with health and safety regulations. Sharps bins were correctly labelled and dated. In the Podiatry clinic we found that a new blade removal system had been introduced in response to incidents were several students had injured themselves whilst removing scalpel blades from handles.
- We observed the equipment store for the active recovery team and found that there were plenty of walking frames, shower boards, bedpans and commodes, which were all clean. A yellow tag system was used to reserve and allocate equipment to patients.
- The Red Cross had the contract for providing equipment to patients in the community. Community nurses said the arrangements worked well. One nursing team said they kept four syringe drivers at their office base to ensure this equipment was accessible.

Quality of records

- Patient records were mainly on an electronic record system. There were some paper notes at the patient's homes but these were minimal. We looked at 22 patient records and found that they were completed accurately and thoroughly.
- Record keeping audits were carried out yearly. Staff told us that the format had changed this year because the majority of patient records were stored electronically.
- Information governance training levels ranged between 67% and 100% for staff working in community services. Some staff groups exceeded the trust target of 90%.

Cleanliness, infection control and hygiene

- A community specific infection control accreditation tool had been developed by the infection control team. The tool enabled community based services to gain accreditation against key infection control standards. We were told that 12 teams had gone through the 12 month programme to gain accreditation and more services had started the programme.
- Training compliance for infection prevention and control was high in some staff groups at 100% however, some groups such as nursing achieved 58% against a trust target of 90%.
- We saw evidence of monthly hand hygiene and reusable equipment audits in community nursing.
- We observed staff effectively washing their hands and using hand gel in between patient contacts. We observed that clinics and offices we visited had adequate supplies of personal protective equipment (PPE) such as gloves and plastic aprons. We observed staff using PPE appropriately in clinics and when they visited patients at home.
- Reusable equipment such as stethoscopes and sphygmomanometers were all appropriately cleansed prior to and following use.
- Podiatry instruments were sterilised at a central location and delivered to each clinic site. We saw that each pack had a detachable tag with details of the pack number. This was attached to the patient's records providing traceability. This showed good compliance with decontamination standards.

Mandatory training

- Compliance with mandatory training was generally high against the trust target of 90%. We saw variation between some teams and staff groups with therapy teams achieving higher levels of compliance compared to other staff groups such as community nurses.
- Staff told us they used the Personal Achievement & Learning Management System (PALMS) to co-ordinate and book onto mandatory training. They could easily access e-learning and book onto face to face training. A rehabilitation assistant showed us that she had attained a gold star on PALMS for being up to date with all her mandatory training.
- One community nursing team told us they had been commended for achieving over 90% compliance with mandatory training.

Assessing and responding to patient risk

Good

Are services safe?

- Community nursing teams used an Early Warning Score (EWS) to identify the deterioration of a patient's condition. A nurse told us that she would call the patients GP, the 111 service or 999 depending on the score.
- Community staff we spoke to were aware of the key risks to patients. For example, risks of falls and pressure damage to skin.
- The community nursing teams completed risk assessments for patients as part of the core patient assessment on the electronic records system. Risk assessments were carried out to identify patients at risk of falls, pressures ulcers, pain and malnutrition. Staff were aware of what action to take to protect patients from these risks and we saw this clearly documented in the notes. Staff were aware of how to refer patients on for specialist assessment or for the supply of additional equipment to manage these risks.
- We looked at 22 community nursing patient records on the electronic system and saw that these were well completed with the exception of the records in one community nursing team, which were inconsistent in the completion of patient risk assessments.
- Acquiring pressure ulcers was one of the biggest risks in this patient group for patients being cared for in the community.Staff told us about resources on the intranet for pressure ulcer prevention which could be accessed from a link on the electronic record system. Patient information was also available and staff could print off the leaflets to give to patients. One example we saw was the 'time to turn' leaflet.
- Pressure ulcers assessed as a severity of grade three or above were referred for investigation as a serious incident and a root cause analysis (RCA) was undertaken.
- A rehabilitation assistant in the active recovery service told us that if they were concerned about a patient or there were problems with the patient's observations they would ring the coordinator or a nurse in the assessment team.

Staffing levels and caseload

- There were four integrated community nursing teams covering the population of Sheffield. Two teams told us they have a full establishment of nursing staff. They said caseloads had increased and so had the complexity and dependency of patients. Another team told us that their caseloads felt manageable however, one team said that they were very busy and had reported staffing levels on incidents forms.
- Team leaders within the integrated community nursing teams told us they reviewed the caseloads daily and allocated patients to nurses. Nurses visited on average 12 to 14 patients a day however this could vary dependant on the individual needs of the patients.
- A safe caseload tool had been developed and was being rolled out across community nursing to establish and record the dependency of patients. The tool graded patients into three different levels of dependency; routine, additional and significant. This enabled nursing staff to manage their workload more effectively. Managers told us this would help them establish more accurately, what their staffing needs were and allow them to plan services more effectively. Managers were aware of the need to review community nursing capacity.
- Community nurses said that they felt under pressure to meet the needs of the patients being discharged from the hospital and those referred from the GPs.
- There was no problem with recruitment into vacant community nursing posts. We were told that there was a list of staff from the local hospitals who wanted to transfer to work in the community. Community nursing also had their own bank staff.
- Staff in the active recovery service were divided into four teams. Each team comprised of nurses, physiotherapists, occupational therapists, rehabilitation assistants and assessment support assistants. Teams met each morning to discuss caseloads. Dependant on demand, there could be flexible movement of staff across teams.
- Rehabilitation assistants told us that they each visited around seven patients a day. If they needed to stay longer with a patient who was unwell, they could ring the coordinators who would rearrange their other calls.

Good

Are services safe?

- The falls service was delivered by 22 staff divided into three teams comprising of a team leader, occupational therapists, physiotherapists, and band 3 and 4 assistants. We were told that there was a high level of vacancies for band 3 assistants in this service.

Managing anticipated risks

- There was a risk register in place that ensured potential risks were identified, assessed and appropriate control measures were implemented.
- Community nursing staff told us about their winter weather plans. In the event of snow, they were able to use 4x4 vehicles from the GP out of hours service to reach patients' homes.
- There were local lone working procedures in community nursing.

Major incident awareness and training

- There were plans to deal with major incidents or events that would disrupt the delivery of care.
- The trust had several staff who had completed the gold, silver and bronze command training. This meant that in the event of a major incident they would perform strategic, tactical and operational command for the organisation.
- The trust had taken part in a scenario based emergency planning exercise in November. This was in collaboration with the City Council, Yorkshire Police and Midlands Rail Incident Team.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We rated the effectiveness of community adults services as good because;

- We found care and treatment was evidenced based with pathways of care based on National Institute of Clinical Excellence (NICE) guidelines. For example, the Sheffield footcare pathway for patients with diabetes was based on NICE guideline NG10.
- We found many examples of multi-disciplinary working and coordinated care pathways. The Active Recovery Team and PhysioWorks were both excellent examples of multi-professional teams working closely together for the benefit of patients.
- Referrals to community services were made through the Single Point of Access (SPA) service, which managed approximately 2100 call per month. The SPA team carried out a telephone triage and established the most appropriate service for the patient.
- Staff had laptops with 4G, which allowed them access to patient records in the patient's home. Staff said this was reliable and they could hot desk at the most convenient location, which saved time travelling back to their base.
- Staff we spoke to had a good level of knowledge about the Mental Capacity Act and Deprivation of Liberty Safeguards. They could give examples of best interest meetings that had been held when patients lacked capacity to make a decision for themselves.

However,

- We observed trust policies on the intranet and found that most were up to date. However, some trust policies such as Safeguarding and Lone Working needed updating.

Detailed findings

Evidence based care and treatment

- The Sheffield footcare pathway for patients with diabetes was based on National Institute of Clinical Excellence (NICE) guidelines NG10 and allowed urgent referrals to be made to the multidisciplinary foot protection team at Northern General or Royal Hallamshire Hospitals by speaking directly to a consultant or registrar.
- The heart failure team planned to see all patients within two weeks of being discharged from the hospital. This complied with NICE guidelines CG108, the management of chronic heart failure in adults.
- The community stroke team worked within NICE guidelines, for example, 'Stroke rehabilitation in adults (CG162)'. We were told that it was not always possible to achieve this due to staffing levels.
- We were told that community nursing care plans were being reviewed to ensure care was based on up to date evidence.
- The Community Falls Prevention Service carried out a level two multi-factorial falls risk assessment with all patients referred to the service. This was in line with NICE guideline CG161 - Falls in older people: assessing risk and prevention.
- We observed trust policies on the intranet and found that most were up to date. However, some trust policies on Safeguarding and Lone Working needed updating.We saw copies of local procedures such as lone working which were up to date.
- Staff could tell us about local audits they were involved in. Mental health staff carried out monthly audits to measure the number and quality of cognitive screening that had been carried out on all patients seen by the active recovery team.
- Specialist tissue viability nurses were working with community nursing teams on the Lower Leg Management project. The project was designed to up skill community nurses to improve outcomes for patients.
- The Single Point of Access (SPA) service carried out regular audits to ensure they were offering an effective service. One audit had highlighted that they were receiving a high number of calls from community

nursing patients asking when their next visit would be. In response to this a calling card was produced by community nurses so they could write the date and approximate time of the next visit on the card and stick it on the patients fridge. This resulted in a decrease of calls from community nursing patients to the SPA.

Pain relief

- Community nurses carried out a pain risk assessment, we saw this documented in patients notes.
- We observed a podiatrist in the PhysioWorks service discussing pain management with a patient in order to inform choice of treatment and establish a realistic expectation of what could be achieved.

Nutrition and hydration

- We saw that community nursing teams used a nationally recognised risk assessment tool, the Malnutrition Universal Screening Tool (MUST) to assess patients at risk of malnutrition. This was completed to a good standard however this was inconsistent in one of the teams we observed.
- Patients requiring additional support with nutrition and hydration, for example with patients with diabetes, were referred to a dietician who provided advice for patients about healthy food choices in relation to their medical condition.

Technology and telemedicine

- A simple assistive technology system called 'Florence' had been introduced for patients with Chronic Obstructive Pulmonary Disease (COPD). This system enabled the patient to monitor their own condition, which included recording vital signs like blood pressure, pulse or oxygen levels. The system could be set up to 'alert' the patient to contact their clinician, send motivational texts, prompts and reminders. Florence was also used by the falls team to send text messages to remind patients to do their exercises. Discussions were taking place with the CCG and Primary Care Sheffield on using Florence for the management of other chronic diseases.
- The electronic patient record system had the facility to upload and store electronic photographs, which could be shared between professionals. For example, community nurses had access to digital cameras and could upload and share images of leg ulcers with the tissue viability nurses in order to discuss a treatment plan.

Patient outcomes

- The active recovery team told us about an outcome measure they were trialling called the Berg Balance Scale. This scale placed a numerical value on exercises and recovery and allowed improvement to be measured.
- The community stroke team planned SMART goals with patients within 3 days of the initial assessment. The goals were based on The Royal College of Physicians National Clinical Guidelines for Stroke. Goals were set and reviewed using a tool on the electronic patient record. Patient's goals were regularly reviewed and complex patients were discussed at weekly multidisciplinary team meetings.
- Physiotherapists in the stroke team told us that they used the Barthel outcome tool to measure patient's progress. We saw a chart, which mapped the difference between the Barthel score on admission and the score on discharge for 346 patients over the period March to December 2015. This demonstrated positive outcomes for the majority of patients. They also used PROMS (Patient-Reported Outcome Measure) to measure the level of a patient's anxiety and depression. Patients would be reviewed at two, five and 11 weeks prior to being discharged from the service at 12 weeks.
- PhysioWorks used the EQ-5D-5L tool to measure patient outcomes. Patients completed the measure at the start and end of treatment. The tool measured five dimensions of health: mobility, ability to self-care, ability to undertake usual activities, pain and discomfort, and anxiety and depression. This information was reported quarterly. At the time of the inspection, the service could demonstrate a 78% improvement in patient outcomes.

Competent staff

- The overall compliance rates for appraisals for community adults had increased in 2015 to 83.7% at the time of our inspection. Most staff we spoke to had completed their appraisals with their line manager. The active recovery team had 91% compliance rates for

appraisals. We looked at two staff records and found both had completed their appraisals in last year. We saw their appraisals were based on the trust values and their objectives had been set.

- The falls prevention team was established as a non-qualified service. A specific multifactorial assessment was completed by a band 4 specialist therapy assistant, from which further referral to other services was triggered. A Band 3 therapy assistant then continued with an evidence based exercise regime, progressing their balance and stamina according to the individual's ability. All band 3 and 4 therapy assistants had undertaken competency training with band 7 qualified staff.Each member of staff participated in supervision sessions with qualified staff on a regular basis, and discussed individual caseloads and individual patients. The falls prevention team worked closely with the integrated community therapy team and those patients who required qualified intervention were referred on to this service.
- Therapy staff received regular clinical supervision. There was little evidence of formal clinical supervision in nursing teams, however we were told that a new policy was being reviewed and would be soon rolled out. Nursing staff told us that if they had a problem or concern the team leader would come out on visits with them to support and give advice. We were concerned with the poor level of supervision for junior nurses.
- There was a good skill mix in the active recovery team.Rehabilitation assistants freed up time for clinicians to concentrate on more specialist tasks. The team had developed a new band 3 role, the assessment support assistant; these staff had achieved the NVQ3 diploma in health and social care.
- Rehabilitation assistants in the active recovery service had completed a two week 'prepare to care course', which included training in communication skills, equality and diversity, first aid and personal care. Staff told us they always felt supported to undertake training.
- Mental health staff provided training to rehabilitation assistants in the active recovery team, which included what to look for with patients with delirium, dementia and depression and how to care for these patients.
- There were good opportunities for staff development. We spoke to a registered nurse who had previously worked as a health care assistant and been supported by the trust to undertake nurse training. Staff of different grades confirmed that training needs were identified as part of appraisal, and they could request further training relevant to their role.
- Staff told us about informal opportunities to learn and refresh their skills. For example, a community nurse had attended a ward at the hospital to refresh her skills in caring for a patient with a tracheostomy prior to the patient being discharged into her care at home.
- Community nurses were encouraged to undertake the community nursing degree and could be released to provide time for their studies.
- Nurses working in the SPA service were given telephone skills training in order to ensure they were effective.
- Community services supported student nurses on placement and received good feedback.

Multi-disciplinary working and coordinated care pathways

- Community pharmacists were integrated into community nursing teams and the active recovery team. Their main functions were to review patient medication, provide governance and to provide staff with education and training.
- Further integration of community nursing and therapy teams was planned. Hot desking and remote working using 4G technology enabled staff to share offices in order to build effective working relationships.
- We saw excellent examples of joined up working with other agencies. For example, the Single Point of Access (SPA) service forwarded calls to the voluntary sector if appropriate to patient's needs.
- The active recovery team was a multi-disciplinary team made up of nurses, occupational therapists, physiotherapists and rehabilitation assistants. The team also had regular input from pharmacy, mental health professionals and had access to a community geriatrician.
- The heart failure team were moving towards a more integrated approach to patient care between acute hospital and community services. One nurse had a specific role to lead on this work.

Good

Are services effective?

- The community stroke team used to be part of the intermediate care team but now stroke care was part of the integrated stroke pathway with services in the acute hospital. Staff told us this led to improved relationships between the staff in the hospital and community, and more effective services for patients.
- PhysioWorks was a community musculoskeletal service that provided treatment for people who suffer from painful joints, muscles or soft tissues in any part of their body. Its aims were to reduce pain and improve movement so that normal daily activities can be carried out. A multidisciplinary team of specialists including physiotherapists, podiatrists, doctors and therapy assistants provided the service.
- The evening and night nursing service was based in the same building as the out of hours GP service. Staff said this meant they could access a doctor if a patient needed medical input, for example, the prescription of pain relief.

Referral, transfer, discharge and transition

- Access to many community services was through the Single Point of Access (SPA) service, which managed approximately 2100 call per month. The service was first commissioned in 2006 and had grown and developed over the years. The SPAteam carried out a telephone triage and established the most appropriate service for the patient. They arranged referrals and appointments with many services such as podiatry, continence clinics, the heart failure team and the specialist falls team. The patient could then be booked in for an appointment at the location of their choice. SPA was also able to forward calls to voluntary agencies or community support workers if patients required other support such as befriending or dog walking services.
- There was good partnership working in the active recovery team. Rehabilitation assistants could visit patients four times a day to provide personal care and after five days, the local authority would take over the care package.
- The community stroke team provided care to patients along a 12 week pathway.A physiotherapist or an occupational therapist assessed patients on the first day of discharge from the hospital. The manager told us that 90% of patients must be discharged by 12 weeks or the service would incur a financial penalty. After 12 weeks, if the patient needed a care package this would be arranged with social services/independent sector.
- Any member of staff within the active recovery team could refer a patient to mental health professionals for a mental health assessment.
- The community nursing team told us that now they were seeing more patients with complex needs, many of them would need ongoing care and therefore would not be discharged from the service.

Access to information

- Community nursing staff had laptops with 4G access. Patient records were stored in an electronic system. Staff told us that this was very reliable and allowed them to access records in the patient's home. It also allowed them to work remotely and they could hot desk at the most convenient location, which saved time travelling back to their base.
- Some GPs also used the same electronic system, which meant that if patients consented, their records could be shared with the community teams. Staff told us it was difficult working with practices who used different IT systems, as it was not possible to share patient information.
- Community staff also had access to an electronic system for looking at patient results including x-rays, blood and microbiology tests.
- The heart failure team used an electronic records system. The hospitals used a different IT system, which sometimes caused difficulties in sharing patient information. However to overcome this staff could hot desk at clinics where they could access the hospital system.
- Mental health professionals within the active recovery team had access to the electronic records system for the mental health trust. This was helpful as it allowed them to see if their patients were already known to the mental health trust.
- Community services received IT support 24 hours a day, seven days a week. Support was provided by the trust and the Commissioning Support Unit (CSU) which provided on call cover over the weekend period.

Good

Are services effective?

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to had a good level of knowledge about the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). They could give examples of best interest meetings that had been held when patients lacked capacity to make decisions for themselves.
- The trust employed a mental capacity act facilitator who delivered training to staff on assessing mental capacity, best interest decision making and DoLS.
- Rehabilitation assistants told us they had completed a day of training about the Mental Capacity Act and Deprivation of Liberty Safeguards.
- We observed staff gaining verbal consent before providing care and saw that patient consent forms were appropriately completed. We also heard patients being asked for consent to share their electronic records with other professionals.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We rated community adult services as good for caring because:

- We found staff were genuinely caring and passionate about the care they provided to patients.
- Patients we spoke to all said they were extremely happy with the care they received and felt they were always treated with compassion.
- We saw staff putting on overshoes when entering patients homes in wet weather. We thought this was extremely considerate.
- Staff identified support options and discussed these with patients and their families before gaining consent and agreement.
- Mental health services aligned to the active recovery team provided talking therapies for patients and could signpost patients to other agencies for example, befriending groups.

Detailed Findings

Compassionate care

- Staff talked to us about patient centred care and that they believed in putting patients first. When talking to staff, they demonstrated they were caring and passionate about the care they provided to patients.
- We observed staff delivering care with compassionate and they were responsive to patient's needs.
- Staff told us they told us loved working in community with patients in their own homes and seeing them blossom.
- We observed good interaction between staff and patients. It was clear that the community nursing teams and community matron knew their patients and families well and had built up good relationships with them.
- We spoke to an occupational therapist and physiotherapist from the active recovery team who said that staff were very caring and would go the extra mile for patients.
- We heard examples of staff working additional hours to ensure patients were cared for. One nurse stayed with a patient who was near to her end of life to ensure her syringe driver was changed.
- We saw staff putting on overshoes when entering patients home in wet weather. We thought this was considerate.
- Patients we spoke to all said they were extremely happy with the care they received and felt they were always treated with compassion.
- Staff told us, whenever possible; they would attend the funeral of patients they had been caring for.
- We looked at Friends and Family Test data for community services for September, October and November 2015. For all three months, results were consistently between 80-90% for patients who would recommend the service to their friends and family.

Understanding and involvement of patients and those close to them

- With patients consent we visited20 patients' homes and observed staff communicating well with patients, giving clear explanations and checking their understanding.
- Staff identified support options and discussed these with patients and their families before gaining consent and agreement.
- Patient's relatives we spoke to said they thought the care provided had been excellent and staff had been caring and responsive.
- We observed community staff working closely with and supporting carers.

Emotional support

- Mental health services aligned to the active recovery team provided talking therapies for patients and could signpost patients to other agencies for example, befriending groups.

Good

Are services caring?

- The community stroke team told us they sign posted patients and carers to services that are available to give them advice and support. For example the Stroke Association.
- Therapists in the community stroke team carried out mood assessments on patients within two weeks of the initial assessment. This assessment detects whether someone is anxious or depressed so a referral can be made for further tests and treatment.

Outstanding ☆

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated community adult services as outstanding for responsive because:

- There was close working with commissioners to provide services along coordinated pathways of care.We saw good examples of community services working closely and planning services with the acute hospitals to provide integrated care to patients.
- The active recovery team had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess. The first ward to implement discharge to assess had a sustained reduction in length of stay of 7 days.
- Access to services via the single point of access was excellent, ensuring patients were seen by the right professional at the right time at a venue of their choice.
- Staff were aware of cultural differences. They told us that patient information leaflets were available in different languages and there was good access to interpreting services.
- Community nursing teams had a dedicated member of staff who was the dementia link. Staff we spoke to had completed dementia training and could describe how they would provide extra support for patients living with dementia.
- There was shared learning from complaints and we saw evidence that changes were made in response to complaints.

Detailed findings

Planning and delivering services which meet people's needs

- There was close working with commissioners to provide services along coordinated pathways of care. We saw good examples of community services working closely and planning services with the acute hospitals to provide integrated care to patients.For example, the community stroke service formed an integral part of the stroke pathway.
- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. There were arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- Managers told us that further work was being undertaken to integrate community nursing and therapy teams and to strengthen joint working with local authority teams.
- Person centred care planning was in place. The aim of this was to provide support for patients considered to be at high risk of hospital admission at an early stage. Community nurses and GPs worked together to develop patient and carers confidence in managing their own health. The community matron supported this. There were locality champions for person centred care planning in each of the four localities.
- Managers told us about workshops, which had been held between integrated community care teams and social care providers in order to understand how each service delivers care and identify areas of overlap and opportunities to co-ordinate services effectively. We saw this in an article in the integrated care update newsletter.
- The Single Point of Access (SPA) service visited other trusts with a similar service to share and exchange information on effective ways of working. Managers used this information to plan and improve the quality of the service they provided.
- Daily operational management meetings were held which involved managers from across the community settings as well as the acute hospital wards. These enabled the teams to work effectively to understand, plan and manage the flow of patients in order to meet their needs.

Equality and diversity

- Staff were aware of cultural differences. This service provided face-to-face interpreters in over 80 languages and telephone-based interpreting services in over 240 languages.

Are services responsive to people's needs?

- Information on the trust website could be translated into over 90 languages at the click of a button.
- We were told that the PhysioWorks service had a website for patients that provided patient information in 10 languages.
- There was good compliance with equality and diversity awareness training. Most teams had achieved over the trsut target of 90%. Some teams had achieved 100% compliance.
- A rehabilitation assistant in the active recovery team was involved in developing the role of diversity champions. This assistant was the Black and Minority Ethnic (BME) champion, which involved leading on training and producing educational materials for staff.

Meeting the needs of people in vulnerable circumstances

- There was a contract in place with the local mental health trust to provide mental health support for patients in the active recovery service.
- The active recovery service aimed to carry out a memory screening test on all patients within the first week. Patients identified as needing further evaluation were referred to mental health professionals within the team for a more thorough assessment and onward referral if needed.
- The active recovery team had bespoke leaflets for the family of patients with dementia. Clinicians highlighted additional wider support for the patient, for example day centres and lunch clubs.
- Community nursing teams had a dedicated member of staff who was the dementia link. Staff we spoke to had completed dementia training and could describe how they would provide extra support for patients living with dementia. For example if patients were better in the morning, they would be given most of their medication then. Staff used wipe boards in patients home to leave reminders for the patient and to communicate with the family and other carers.
- A communication sheet had been developed and was in use at patient's homes for patients living with dementia or patients with communication difficulties. This was to ensure that the patient's relatives were kept informed and it provided a method for two way communication.This was devised in response to relatives complaining that when the new paper light notes were introduced, they no longer knew what was going on.
- Staff told us they were 'dementia friends' and we saw they were wearing the dementia friend badge. Dementia friends is a programme run by the Alzheimer's Society's which allows people to learn about what it's like to live with dementia and then turn that understanding into action.
- The podiatry service provided care and treatment for hard to reach groups such as the homeless.
- Nursing staff had good local knowledge, which enabled them to support patients to access local services and community groups. They could refer patients to community support workers who they said were 'a fantastic support'.

Access to the right care at the right time

- We found services for community adults to be accessible and timely.
- The Single Point of Access (SPA) service managed referrals from patients and health professionals into all community health services. It was available 365 days a year, . Outside of these hours the calls were answered by the GP Collaborative. The service used a call routing system to direct patients to the right professional from the start. The team had extensive local knowledge and specialist expertise and were able to access to up to date information on service capacity. This meant that they could give advice on which service would be most appropriate for the patient. Once referred to a service, confirmation was sent to referrers to ensure they were kept informed of who was caring for their patients. The aims of the service were to ensure patients were seen by the right professional at the right time at a venue of their choice. We thought this service was outstanding.
- The active recovery service could see a patient within two hours of receiving the referral and was available from 8am - 2am, seven days a week. The team had redesigned the traditional model of assessing to discharge to the more patient centred approach of discharge to assess. The first ward to implement discharge to assess had a sustained reduction in length of stay of 7 days. The service had provided support for

Are services responsive to people's needs?

over 6300 patients transferring from hospital back to home over the previous 12 months. We saw evidence that showed on average, a 2.4 day reduction in delay across the hospital-community interface, which represented a reduction in hospitalisation of over 15,000 bed days.

- There were two nurses in the intravenous (IV) team who delivered intravenous antibiotic therapy for patients in their homes. Patients with conditions such as severe cellulitis could be given their first dose of intravenous antibiotics then transferred to the community nursing teams to continue their care. This meant these patients would not need to be admitted to hospital as they could have their care at home.
- The heart failure team had originally seen all patients at home. This was time consuming with staff travelling from one patient to another. They identified that some patients could travel to local clinics and developed criteria to assess patient's ability to attend a clinic appointment.Patients not able to travel to the clinic were still seen at home. This resulted in waiting times being reduced from three weeks to two weeks.
- The integrated community nursing teams delivered services from 8am to 6pm, and the evening and night service provided nursing cover from 6pm until 8am. This meant there was 24 hour cover, 7 days a week.
- The community stroke service was available from 8am until 5pm, 7 days a week. At weekends, there was only one therapist and one rehabilitation assistant available.The aim of the service was to support early discharge from the hospital and provide continuing rehabilitation.
- At one podiatry clinic we inspected there was a facility to manufacture and adjust foot orthotics on site. This meant that patients received their appliances in a timely way, as they did not have to be sent out to an external laboratory.
- We were told that the average waiting time for a podiatry appointment was three months however, referrals were risk assessed to ensure those with the highest clinical need were seen first.

Learning from complaints and concerns

- Staff told us that complaints were dealt with as early as possible before they escalated. Managers investigated formal complaints. Managers shared learning from complaints with staff in team meetings.Staff gave us an example where a relative of a patient living with dementia had complained because when records became electronic they were no longer able to see what was happening withcare. As a result, staff introduced a communication sheet for relatives, which was left at the patients homes.
- We saw information about the Patient Liaison Team displayed on notice boards in all the clinics and health centres we visited.

Outstanding ☆

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated community adult services as outstanding for well led because:

- Senior managers could articulate their vison and strategy and shared this with staff.
- There was strong leadership at both senior and local level. Staff spoke highly of their managers and felt well supported and listened too.
- Senior managers were often seen and staff said they were approachable.
- Staff were highly engaged and felt valued.
- There were innovative services along pathways of care, which reached across both hospitals, and community services.

Detailed findings

Service vision and strategy

- Staff and managers we spoke to were aware of the trust vision and strategy.
- There was a five year Directorate Strategy for Primary & Community Services.
- Senior managers were clear about their service vision to create a multiprofessional integrated service of core community based teams.They described their rationale behind the community restructure and how this would lead to more integrated community services. Workshops had been held in each locality to involve staff in creating the shared vision and strategy for integration.
- Staff in the active recovery team could explain to us how their role linked with the overall aims of the care group and the trust.

Governance, risk management and quality measurement

- We found that there were robust assurance structures in place to ensure that services were safe.
- Senior managers for community services were aware of their top three risks and had plans in place to mitigate or reduce these risks. We saw these documented on the risk register.
- Each service within community adults had a governance lead and there was a risk register in place to ensure potential risks were identified, assessed and appropriate control measures were implemented.
- We saw that risks were a standard agenda item for staff meetings and team leaders could escalate any concerns up through the directorate governance structure.
- There was a risk and governance lead in each directorate. Managers told us that they attendedgovernance meetings every three months. Risks, complaints and incidents would be discussed with the risk and governance lead. Information from these meetings was shared with staff at team meetings.
- Quality forums were held quarterly and enabled good practice to be shared.

Leadership of this service

- Managers told us they were very proud of their staff and that they went over and above what was expected of them.
- The matron for the heart failure team was new in post (2 months). Staff were very positive about her leadership and the changes that were being made to improve the service.
- Staff told us that they felt well supported by their managers and gave examples of when their managers had sensitively handled staff issues such as long term illness.
- We heard examples of managers consulting with teams during service changes and developments. . Managers had involved them in discussions, asked their views about the change and how they thought it could best be

implemented. Initially managers asked volunteers to work weekends and there was no problem with this. Staff felt they could voice concerns about the changes, and managers listened.

- Managers had put good systems in place to keep staff safe. For example, there were local lone working procedures in community nursing. We saw a photograph of each member of staff standing beside his or her car. This was pinned up on a notice board in the office of the integrated community nursing teams. In the event of a member of staff going missing this would be shared with emergency services. Staff had been given a torch with a personal alarm fitted and ensured they went out in pairs after 5pm.
- Teams reported good communication from managers. We were told that managers had an open door policy. The active response sub teams met each day and sub team leaders had regular meetings with their operational managers. Managers flexed their hours and the times of staff meetings, in order to make the meetings accessible to as many staff as possible.
- Senior managers were often seen and staff said they were approachable. Local managers felt well supported and valued.
- Staff sickness was actively managed using an agreed process. We were told that staff absence rates had reduced on average from 11% to 4.5% in the active recovery service since this procedure had been implemented. The procedure could be adjusted for staff with a disability. Staff with a good attendance rate for the year received a letter from the chief executive. The sickness rate for staff in community was 6.6%, which was higher than the trust target of 4%.
- Staff told us about regular email communication they received from the chief executive and some staff we spoke to had met the chief executive, others knew his name.

Culture within this service

- We found a positive staff culture in community services. Staff enjoyed their work and were patient centred in their approach.
- There was a culture of continuous service improvement and change. We saw evidence of and heard about many service improvements, which were taking place. Examples were the development of the safe caseload tool for community nursing and the development of an integrated stroke pathway for Sheffield patients.
- There was a positive culture of integrated working across professions, acute, community teams, and other agencies to improve patient care.

Public engagement

- The active recovery service had a patient experience group.Feedback from patients was used to improve services. For example, patients said they preferred to know what time staff would be coming so staff now ring them to give a better idea of what time to expect them.
- The community stroke team hosted a carers' group who met regularly. The team carried out patient/carer interviews and this was fed back to staff at the team meeting. Care stories from patients were shared with staff at meetings and used for reflection and learning. We saw evidence of this in minutes of team meetings.
- The Single Point of Access (SPA) service carried out regular patient satisfaction surveys. Patients were called 48 hours after contact with the service and asked set questions about their experience of using the service. They were asked if they were satisfied, not satisfied or not worried either way.
- Patient feedback was displayed on notice boards. This included 'patient of the month' interviews.
- The trust participated in the Friends and Family Test.

Staff engagement

- We found that morale was generally high amongst community staff. Staff told us they felt valued, supported and well managed.
- A community occupational therapist told us that she felt valued when she was personally thanked at a special lunch provided for community staff who helped in the hospital during the winter pressures.
- Staff we spoke to knew about the trusts PROUD values. A manager told us that the trust values came from grass roots and helped to maintain patient focused care.

Outstanding ☆

Are services well-led?

- We found many examples staff engagement and involvement in change. For example, staff in the active recovery team told us that they had been consulted and felt able to influence how the service had developed.
- Staff in the heart failure team had been involved in reviewing the service and making improvements. They had regular monthly meetings. Each meeting was divided into two parts the first part included the administration team and business manager. The second part was for clinical staff to discuss clinical matters and service changes. We saw this reflected in the minutes of these meetings.
- Administration staff in the active recovery team said they worked really well together as a team. They felt well supported in a good working environment with excellent managers who were accessible.
- Staff felt listened too and could give examples of how their feedback had been acted on by managers. One example given was staff in the active recovery team had discussed with managers their problems with parking when they returned to their base after visiting patients. Following this, designated parking spaces had been allocated to them.
- We saw 'you said, we did' information from staff displayed on notice boards. An example of this was, you said 'we are not confident in completing the [electronic] incident reports' so we have emailed out a how to guide to staff on [electronic] incident reporting.
- Staff told us about a 'listening into action' event the trust had organised. They said that action had been taken on a number of points raised and they received regular feedback following the event.

  One example of changes made because of the event was that parking charges for bereaved relatives were now free.
- We saw posters displayed on notice boards in staff areas, which contained information on what the team were proud of.

Innovation, improvement and sustainability

- We found a culture of continual service improvement and innovation in adult community services. Services had been redesigned and projects were underway to ensure integration between community and the acute hospital services. This allowed services to be delivered along a pathway of care. We saw examples of this in the integrated stroke pathway and the musculoskeletal pathway. There was also involvement in a regional project to integrate physical and psychological wellbeing. This project aimed to test whether improved access to talking therapies for people with physical health problems who also have common mental health problems.
- The active recovery team was an innovative service. It was the first in the England to provide this model of care and had been cited by the Royal College of Physicians as an exemplar of good practice. The team won a Sheffield Teaching Hospital award for cost efficiency.